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# Potential Impacts of Delaying SCHIP Legislation

John McInerney, Program Manager
National Academy for State Health Policy

## Introduction

Enacted in 1997 with bipartisan support, the State Children's Health Insurance Program (SCHIP) has been very successful at providing coverage for low-income children. Enrollment has grown steadily, reaching 6.6 million in 2006. The initial ten year authorization for SCHIP expired on September 30, 2007, leaving states unclear about the future federal commitment to the program. While Congress agreed on a $35 billion, five year reauthorization bill, the legislation was vetoed by President Bush on October 3. The House of Representatives fell short of a veto override.

As of early December 2007, SCHIP is funded at last year's FY 2007 level ($5 billion) under a temporary continuing resolution.[1] The first continuing resolution expired on November 16, and the current extension is set to run out on December 14. If funding continues at last year's level, a significant number of states will face difficulty in financing their SCHIP programs. According to the Congressional Research Service (CRS), 21 states will not be able to fully fund their programs throughout the current fiscal year without additional resources.

The looming funding shortfalls are necessitating state planning and may soon require state action that could impact coverage for children. Based on NASHP's discussions with states regarding their current funding uncertainty, it appears failure to reauthorize may result in:

- The imposition of waiting lists, caps on program enrollment, disenrollment of children from the program, or other cost saving measures.
- A reduction or delay in outreach efforts to reach eligible but unenrolled children.
- Challenges and costs in regaining lost enrollment if funding is later increased.
- Erosion of confidence in the program on the part of families and state policy makers.
- Uncertainty for states on whether they will be required to comply with new anti-crowd out guidance from the Centers for Medicare and Medicaid Services.[2]

Some states are beginning to make decisions in response to the current situation. For other states facing shortfalls, a lack of timely funding will require state policy makers to consider program and funding changes when legislatures reconvene in January. This paper will discuss the potential consequences of a continued failure to provide adequate support for states to maintain and improve their SCHIP programs.

## States May Have To Reduce Enrollment

The most significant effect of delay in reauthorizing SCHIP is that states may need to stop enrollment, erect enrollment barriers, or even disenroll children from the program. Funds will

run out for a number of states starting in March; these states will need to take action before their federal funds run out to avoid the possibility of having to disenroll all children from SCHIP once the shortfall in funding begins.

CRS estimates the total FY 2008 shortfall at $1.6 billion if the program remains at level funding throughout the fiscal year. In the past, Congress has appropriated additional money to prevent state shortfalls, including earlier this year when $650 million was added for eleven states. However, with the magnitude of the current estimated shortfall and the contentious reauthorization debate, many states are uncertain if they can count on full shortfall relief in the coming months. A number of these states have already begun to consider cost-saving measures to ensure they can live within budgets in the event that sufficient funding is not authorized.

California, a state with approximately one-sixth of all SCHIP enrollees nationwide (850,000 children in the state are in the program), is actively considering a variety of options to address an estimated $340 million shortfall in FY2008. Under a temporary extension with no increases in funding, the state is projected to run out of federal funds in June.

California has outlined three possible options to address a shortfall: a) maintain the status quo and hope sufficient funding is achieved; b) close enrollment and create a waiting list; or c) begin a process of disenrolling children in January 2008. None of these options present California with a desirable solution. However, if the state takes no action and sufficient funding is not appropriated, coverage for all 850,000 children could be at risk.

Closing enrollment and creating a waiting list likely would not provide enough savings to prevent the need to disenroll at least some children currently receiving SCHIP coverage, according to state administrators. If the state chooses to begin a month-by-month disenrollment nearly 57,000 children will lose coverage in January, and an average of 66,000 children will be disenrolled per month (at the time of annual renewal) between January and the end of the current federal fiscal year in September 2008.[3]

Preparing for the possibility of insufficient funding, the agency that administers the program for the state, the Managed Risk Medical Insurance Board (MRMIB), approved regulations on November 5, 2007 that would allow the creation of waiting lists or the disenrollment of children from the program.[4] Absent a reauthorization deal or longer term SCHIP extension with additional funding, MRMIB will soon decide California's next steps to address the shortfall.

## State Outreach Initiatives Are Threatened

A key bipartisan goal in the SCHIP reauthorization process has been for states to better reach children eligible but unenrolled in SCHIP and Medicaid. However, as the reauthorization process drags out and with flat temporary funding, states are beginning to consider cutting back on their outreach efforts.

Without the assurance of a continued SCHIP funding stream, states worry that bringing more children into the program could jeopardize states' ability to cover already enrolled children. States are also wary about offering coverage to children they may have to disenroll if funds run

## Table 1. SCHIP Projected Funding Shortfalls for Fiscal Year 2008

| 2008 Month of Shortfall | Shortfall State | Projected Shortfall (millions) |
|---|---|---|
| March | Alaska | $11.8 |
| | Georgia | $199.9 |
| | Illinois | $253.2 |
| | Iowa | $35.8 |
| | Maine | $17.3 |
| | Maryland | $88.7 |
| | Massachusetts | $157.3 |
| | New Jersey | $191.1 |
| | Rhode Island | $44.1 |
| April | Minnesota | $41.6 |
| | Mississippi | $55.8 |
| May | Missouri | $44.2 |
| | Nebraska | $14.1 |
| | North Dakota | $4.9 |
| June | California | $342.5 |
| | North Carolina | $49.5 |
| July | Oklahoma | $21.5 |
| August | Arkansas | $16.6 |
| September | Louisiana | $3.9 |
| | Ohio | $11.9 |
| | South Dakota | $0.7 |

Source: Peterson, Chris. Congressional Research Service, Report for Congress: FY2008 SCHIP Allotments, based on data provided by the Centers for Medicare and Medicaid Services (CMS), October 2007

out. For these reasons, some states are considering putting new outreach on hold until SCHIP reauthorization is completed. If the delay continues, states may be forced to consider curtailing all outreach until new federal funding is approved.

The potential impact on children's coverage can be illustrated by Louisiana's situation. The state has been extraordinarily successful at enrolling children in SCHIP and Medicaid over the past decade. Between 1999 and 2005, the percentage of all uninsured children in the state fell from 23.8 percent to 8.4 percent, largely as a result of increased enrollment in SCHIP and Medicaid. The percentage of uninsured low-income children below 200 percent of the federal poverty fell even more dramatically, from 31.6 percent in 1997-1999 to 10.9 percent in 2006, as Louisiana went from the fifth highest percentage of uninsured low-income children to the tenth lowest. [5] The state simplified enrollment procedures through facilitated enrollment,[6] as well as other outreach strategies such as sending applications home with students, provider education, and producing public service announcements to advertise the program.[7]

Despite the huge setback from Hurricane Katrina, Louisiana continued to move forward in 2007 by enacting legislation to increase the income eligibility for LaCHIP (Louisiana's SCHIP program). The legislature also added new money for outreach that may ultimately be curtailed given the current troubles with SCHIP funding levels. State decisions to delay or reduce outreach are made very reluctantly because of the potential detrimental effects on enrollment, and states generally are continuing outreach in the hopes that increased funding will be provided soon. However, if SCHIP funding is not increased in the coming weeks, Louisiana and other states could be forced to consider cost-saving measures that could include curtailing outreach efforts, thus stalling or reversing the success achieved over the past decade.

## Program Changes Often Difficult to Reverse

States that are forced to make cost-saving changes to their SCHIP programs as a result of anticipated funding shortfalls will likely find that changes, as well as their effects, will take time to reverse when funding is available again. It is seldom easy to reinstate policies or reverse enrollment declines.

For example, Texas responded to a fiscal crisis in 2003 by approving administrative rules designed to lower enrollment. These rules included reducing continuous eligibility from twelve to six months (making families renew coverage twice in one year), implementing a $5,000 asset limit, and eliminating all deductions from income, such as child care costs.[8] The changes reduced coverage significantly, as enrollment declined by over 200,000 children over the next four years.[9] In 2007, Texas rolled back many of these enrollment barriers by returning to a 12 month continuous eligibility and increasing the asset limit to $10,000. Even with these new policies, the state is finding that it is challenging to gain back the lost enrollment. Texas is expected to add only 100,000 children to the program by the end of 2009, recovering only half of the children dropped from enrollment.[10]

Other states have had similar trouble reversing program changes and building back enrollment. Florida implemented a waiting list and limited open enrollment (in 2003 and 2004) in its KidCare program, largely because of uncertainty that future SCHIP funding would keep up with enrollment levels. The barriers had a precipitous outcome, with approximately 130,000 children losing coverage over the next two years. The state ended the waiting list and opened enrollment in 2005, but enrollment continued to decline slightly as many families with children eligible for the program were either unaware that enrollment had reopened or reluctant to embrace the

program. In July 2007, Florida intensified outreach efforts and allocated additional funding to cover up to 36,000 children. To date, however, only 16,000 children have been added to the program, about 12 percent of the number of children that originally lost coverage.[11]

## Confidence in Program Could Erode

By most measures, SCHIP is seen as a tremendously successful program with great support from state and federal lawmakers and the general public. Yet, the protracted SCHIP reauthorization process may start to undermine faith in the program. Lawmakers and officials tend to dislike uncertainty in program funding streams, while the public could be dissuaded from even applying if they are unsure of SCHIP's availability or the stability of coverage.

A key test of state government and public confidence could soon occur in Georgia. For the second time in less than a year, the state is on the verge of a funding shortfall in its SCHIP program, PeachCare. In March 2007, Georgia experienced a significant shortfall,[12] and borrowed state funds from its Medicaid program to keep PeachCare operational. The state also instituted an enrollment freeze for four months. This stabilized the program until $650 million in shortfall relief for 11 states was signed into law by President Bush in May 2007.[13]

If a longer term solution is not enacted soon, Georgia will be short of SCHIP funding beginning in March 2008.[14] The state is estimated to need $200 million in additional federal funding through the current fiscal year to finance coverage for the approximately 270,000 children enrolled in its program. Based on comments from state lawmakers, it is unlikely Georgia would again borrow money to forestall a shortfall, unless federal relief appeared imminent. Facing the second fiscal crisis in the program in less than a year may erode faith in the program in the legislature. When it reconvenes in January, the Georgia legislature may look at lowering the income eligibility, currently set at 235 percent of the federal poverty level, or consider other measures to cut program costs.

The uncertainty and loss of faith can also extend to families with children enrolled or eligible for the program. States are concerned that current enrollees may consider leaving the program and potential enrollees might be dissuaded from applying out of concern that the coverage may not be sustainable or reliable (as was the case for many in Florida). State officials in Georgia have speculated that families with children in treatment for serious illnesses will worry whether future treatment will be covered.[15]

## Federal CMS Letter Leaves States Uncertain

The lack of a timely SCHIP reauthorization also creates uncertainty for states that may be required to comply with the August 17, 2007 letter to state officials from the Centers for Medicare and Medicaid Services (CMS). The letter imposed new conditions on states covering or seeking to cover children above 250 percent of the federal poverty level (about $52,000 for a family of four). The Children's Health Insurance Program Reauthorization Act of 2007 (CHIPRA) would have put aside the CMS letter, instead mandating a phasing in of anti-crowd out guidelines by 2010. Without a legislative remedy, CMS expects states to comply with its guidance by August 17, 2008. Currently, with the legislation unresolved, states affected by the

letter are uncertain whether they can move ahead with policies that already have been implemented or approved by state legislatures and Governors.

The CMS letter includes a number of requirements that would be very challenging, if not impossible, for states to meet.

Before states can offer coverage for children with family income above 250 percent of the federal poverty level,[16] the letter requires them to: cover 95 percent of eligible children below 200 percent of the federal poverty level; institute a one-year period of uninsurance before coverage can be offered (apparently with no exceptions allowed); prove that private insurance coverage for children in the state had not declined by more than two percentage points in the previous five years; and show that cost-sharing requirements are not more than one percent (of family income) favorable to the SCHIP plan as compared to a competing private plan.

Currently, no state reaches 95 percent coverage of the eligible population of children in families below 200 percent of the federal poverty level. No state has a one-year waiting period without exceptions.[17] In addition, private insurance coverage rates have been declining for adults as well as children for a number of reasons that a state generally cannot control.

Without a legislative resolution, states are unsure on how to proceed in managing their programs. Nineteen states currently provide coverage to children above 250 percent of the poverty level, and the new rules call their established coverage eligibility limits into question.[18] Additionally, a number of states passed legislation in 2007 to cover more children. These states need to gain CMS approval before implementing eligibility changes, and since the August 17 letter was released CMS has not granted any new approvals for programs that attempt to set eligibility above 250 percent of the federal poverty level.

## Conclusion

Continued uncertainty over SCHIP reauthorization funding puts a number of state programs in danger of financial shortfalls. States must consider options to keep their programs solvent. Any of these options carry negative consequences for children's coverage. The full costs of delay are unknown at this point, but the potential risks are clear.

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[1] The annual current funding of $5 billion (FY 2007 level) was determined in 1997 when SCHIP was enacted.
[2] A provision in the Children's Health Insurance Program Reauthorization Act of 2007 would set aside and replace these regulations.
[3] http://www.mrmib.ca.gov/MRMIB/HFP/SCHIPFactSheet-PolicyFocus_11-2-07-FINAL.pdf
[4] http://www.mrmib.ca.gov/MRMIB/Healthy_Family_Program_Emergency_Regulations_Disenrollment_Waiting%20List.pdf
[5] The tragedy of Hurricane Katrina caused a steep increase in the total percentage of uninsured children and the percentage of low-income uninsured in 2006.
[6] Facilitated enrollment is a community-based system where organizations (hospitals, schools etc.) can be authorized to help families navigate the enrollment process.
[7] N. Kaye, C. Pernice, A. Cullen. *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs* (Portland, ME: National Academy for State Health Policy, 2006).
[8] D. Bergman, C. Williams, C. Pernice. *SCHIP Changes in a Difficult Budget Climate: A Report from a Three-State Site Visit*, (Portland, ME: National Academy for State Health Policy, April 2004).

[9] http://www.hhsc.state.tx.us/research/CHIP/CHIPEnrollIncomeGroup.html
[10] Academy Health, *Stateside*, June 22, 2007. http://www.statecoverage.net/stateside0607.htm
[11] J. Taylor Rushing. "Kid Care open; spread the word," *Florida Times-Union*, November 26, 2007. http://www.jacksonville.com/tu-online/stories/112607/met_220472463.shtml
[12] Prior to additional federal funding, shortfall was estimated at $131 million for FY 2007.
[13] http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_cong_bills&docid=f:h2206enr.txt.pdf
[14] A total of nine states are estimated to face a shortfall in March. See Table 1 for a complete list of estimated shortfall states for FY 2008.
[15] Lori Yount. "PeachCare awaits SCHIP outcome," *Chattanooga Times Free Press*, November 7, 2007. http://www.timesfreepress.com/absolutenm/templates/local.aspx?articleid=24767&zoneid=77
[16] According to CMS, the 250 percent limit is a gross limit. Income deductions for child care and other costs that push total income above 250 percent of poverty are not be allowed under the CMS guidance.
[17] A number of states, including New York, California, Illinois, and New Jersey, are pursuing a legal remedy, contending that CMS did not comply with the federal Administrative Procedures Act for rulemaking.
[18] Dennis Smith of the Centers for Medicare and Medicaid Services has indicated only new enrollees would be impacted, but CMS has not released formal guidance on whether the requirements would apply to current as well as new enrollees.

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**www.nashp.org**

Portland, Maine Office:
50 Monument Square, Suite 502, Portland ME 04101
Phone: (207) 874-6524

Washington, D.C. Office:
1233 20th St., NW, Suite 303, Washington, DC 20036
Phone: (202) 903-0101